SUBSTANCE ABUSE REHABILITATION PROGRAM

ALCOHOL AND DRUG ASSESSMENT

1. Have you ever participated in a substance use screening or been treated for a substance related disorder before? YES or NO
If YES, please explain (when, where, why etc)?_____
_____

2. In your own words, why are you here today. _____
_____

3. Describe any learning difficulties you may have and your preferred method of learning.
_____

4. Please use the scale below to describe any physical pain you are currently experiencing:

0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate Pain					Worst Possible Pain

5. When you drink/use, how much do you usually drink/use? (Use this chart to help you; place the number of drinks in the blanks. Write other substances on the line beneath.)

HARD LIQUOR	WINE	BEER
____ Shots	____ Glasses of wine	_____ Can/bottles of beer
____ Mixed drinks	____ "Wine coolers"	_____ Qts/ltrs of beer
____ Pints of liquor	____ Bottles of wine	_____ Pitchers of beer
____ Fifths of liquor		

_____
_____

6. How long does it usually take you to drink/use your usual amount? _____

7. What is the most you ever drank/used in a 24 hour period? (Use this chart to help you, place the number of drinks in the blanks; write drugs on the line beneath.)

HARD LIQUOR	WINE	BEER
____ Shots	____ Glasses of wine	_____ Can/bottles of beer
____ Mixed drinks	____ "Wine coolers"	_____ Qts/ltrs of beer
____ Pints of liquor	____ Bottles of wine	_____ Pitchers of beer
____ Fifths of liquor		

_____

Describe the situation/circumstances_____
_____

8. My friends, (circle all that apply), drink/use drugs, advise me, do things that get them in trouble, encourage my treatment involvement, think I have a problem with drinking/drugs, go to treatment for their own use of alcohol or drugs.

Patient Name		Rank/Grade	Sex
SSN/Identification Number	Status	Date of Birth	
Branch of Service	Organization		
Sponsor's Name	Relationship to Sponsor		

ALCOHOL AND DRUG ASSESSMENT (Cont'd.)

9. Do you resent others talking about your drinking/drug use? YES or NO

10. Are you presently living alone as a result of your drinking/drug use? YES or NO

11. When you drink/use drugs, is it your intention to get drunk/high? YES or NO

12. Please check all that apply and complete the information for each category as requested:

Alcohol	□ Beer □ Liquor □ Wine		
First Use:	Last Use:	How often:	Quantity:
Cannabis	□ Marijuana □ Hashish		
First Use:	Last Use:	How often:	Quantity:
Narcotics	□ Heroin □ Vicodin □ Morphine □ Demerol □ Other:		
First Use:	Last Use:	How often:	Quantity:
Stimulants	□ Methamphetamines □ Amphetamines □ Cocaine □ Crack		
First Use:	Last Use:	How often:	Quantity:
Depressants	□ Valium □ Xanax □ Barbiturates □ Other:		
First Use:	Last Use:	How often:	Quantity:
Hallucinogens	□ LSD □ Mescaline □ Peyote □ Mushrooms □ PCP		
First Use:	Last Use:	How often:	Quantity:
Inhalants	□ Amyl Nitrite □ Glue □ Paint □ Spray cans □ Inhalers		
First Use:	Last Use:	How often:	Quantity:
Designer Drugs	□ MDMA □ Ecstasy □ GHB □ Special K □ Rohypnol		
First Use:	Last Use:	How often:	Quantity:

13 What is/are your drink/drug(s) of preference?_____

14. Do you use tobacco products? (If YES, circle all that apply) YES or NO
Cigarettes/ Cigars/ Chewing Tobacco/ Other

15. How much do you use and how often do you use these products now:
Amount: days/week/month:

Patient Name	Rank/Grade	Sex

16. Who in your family currently has or has had a problem with alcohol, medicines or other drugs? (circle all that apply)

Mother	Father	Brother(s)	Sister(s)	Grandparents
Uncle(s)	Aunt(s)	Guardian	Stepfather	Stepmother
Spouse	Child	Other	None	

17. Have you ever kept drinking or using drugs for long periods without sobering up? YES or NO

18. In the past 12 months, has the amount you drank or used drugs Increased or Decreased

19. Have you found that you need to drink more or use more drugs in order to get drunk or high? YES or NO

If YES, please explain? _____

20. When you consume your normal amount of alcohol do you function _____ than you did in the past? (Circle one)

BETTER THE SAME ABOUT THE SAME WORSE MUCH WORSE

21. Have you ever experienced any of the following when you stopped or cut down on your use of alcohol or drugs? (circle all that apply)

Hand tremors	Severe shakes	See or hear things not there	Rapid heartbeat
Nightmares	Loss of appetite	Jittery/Nervous	Seizures/Convulsions
Weakness	Restlessness	Excessive sweating	Sleeping difficulties
Upset stomach/nausea/vomiting		Other_____	

22. Have you had a drink or taken a drug first thing in the morning, or at other times of the day to steady your nerves or to get rid of a hangover? YES or NO

23. Have you ever had medical help or been seen by the emergency room for alcohol or drug related symptoms (i.e., had a drunk watch, dehydration, vomiting, intoxication, alcohol poisoning, etc.)? YES or NO
If YES, when and where? _____

24. Have there been times when you drank or used drugs more or longer than you intended to? YES or NO

If YES, when was the last time this happened? _____
How often does this happen?_____
Under what circumstances does this happen? _____

Some people make rules for their drinking or drugging (like not using before 5 o'clock; not drinking or using drugs and driving; setting limits (amount of time or money)).

25. Have you ever made rules like that for yourself? YES or NO
If YES, what rules did you make and why?

_____
_____

How successful have you been at following this/these rule(s)? _____

26. Have you ever thought you should cut down on your drinking or other drug use? YES or NO

Patient Name	Rank/Grade	Sex

ALCOHOL AND DRUG ASSESSMENT (Cont'd.)

27. Have you ever attempted to cut back or stop drinking or using drugs? YES or NO

If YES, how many times have you tried to cut back? _____
Why? _____

28. Have you ever hidden your alcohol or drugs from others (i.e., hide beer from your roommates or in several places to ensure you never ran out)? YES or NO
If YES, what did you do? _____

29. Have you ever found yourself scheduling your activities so you could get something to drink or use drugs? YES or NO

30. How much time do you spend drinking/using drugs or recovering from its effects? (i.e., 1 hour per day, 2 days a month, etc.)_____

31. How often do you have hangovers or side effects from your use (i.e., headaches, nausea, etc.)?
_____

32. As a result of your drinking or drug use, have you cut back or stopped doing things that used to be important to you? (e.g., hobbies, sports, family functions) YES or NO

33. Have you found that the people you hang out with have changed as a result of your alcohol or other drug use? YES or NO

34. Do you find that most of your recreational activities involve drinking or drug use before, during, or after your participation in them? YES or NO

35. Have you ever been told that you should not drink or use other drugs because of a medical condition or medications you are taking, and did so anyway? YES or NO
When/why?_____

36. Have you ever been injured or hospitalized due to alcohol or drugs? YES or NO

37. Have you ever had problems with any of the following feelings before(B), during(D) or after(A) a substance use session? (circle all that apply and indicate B, D, or A)

Depression	Fear	Lack of motivation
Anxiety	Nervous	Feeling like killing yourself
Anger	Hurting someone	Feeling like people are out to get you
Feelings of shame/guilt		None of the above

Other _____

38. Has your drinking or drug use affected your sleep? YES or NO

39. Has anyone ever told you that you did something you can't recall after a night of drinking or using drugs? YES or NO

If YES, how often has this happened?_____

40. Has your drinking/drug use ever caused you to miss work or be late to work? YES or NO

41. Has your drinking or drug use ever resulted in your supervisor reprimanding or counseling you? YES or NO

Patient Name	Rank/Grade	Sex

42. Due to drinking or drug use, have you ever had an advancement recommendation withdrawn, evaluation mark lowered, orders modified, or lost a job? YES or NO

43. Have you spent money on drinking or other drugs that should have been spent on other important items? (i.e., food, clothing, bills, etc.) YES or NO

44. Have you ever accidentally hurt or injured yourself or someone else when you have been drinking or using drugs? YES or NO

45. Where do you drink most of the time? BAR HOME FRIENDS OTHER

_____

If you drink at someplace other than where you live, how do you get back home? (Circle as many as apply.)

Walk	How often _____(i.e., 2 times per week)
Bicycle	How often _____
Taxi	How often _____
Drive	How often _____
Friends drive	How often _____

46. Have you ever participated in high-risk activities (driving a motor vehicle, rock climbing, water skiing, etc.) while intoxicated, high, impaired or while recovering from the effects of alcohol or drug use? YES or NO

If YES, when? _____

47. Do you have any past, current or pending military or civilian legal problem or concerns? YES or NO

CHARGES INVOLVING ALCOHOL OR DRUGS: (circle all that apply)

Disorderly	Conduct	Drunk and Disorderly	Public Intoxication
Underage Drinking	DUI/DWI/OUI	Assault	Battery
Open Container	Drug Paraphernalia	Domestic Violence or Abuse	
Urinating in Public	Resisting Arrest	Other_____	

List dates of arrest or detainment(s)	Reason(s)
_____	_____
_____	_____
_____	_____

48. List any military disciplinary actions you have had: (circle all that apply)
Counseling Sessions (written or verbal), Disciplinary Review Board, XO's Mast, Captain's Mast, Court Martial, Letters of Instruction, Letters of Reprimand

List dates of disciplinary action	Reason(s)
_____	_____
_____	_____
_____	_____

Patient Name	Rank/Grade	Sex

49. Have any of the following people expressed concern or commented about your drinking? (circle all that apply)

Parents	Family members	Significant other
Children	Co-workers	Supervisor
Friends	Health care provider	Religious advisor
Other _____		

50. Do you continue to drink or use drugs even though family/friend problems have occurred? (i.e., arguments with your spouse/significant other about your drinking, physical/verbal/emotional abuse, or separation)

51. How often have you felt guilt or remorse over how you have treated others as a result of your alcohol or other drug use? (Circle the closest answer.)

Daily or almost daily Weekly Monthly Less than Monthly Never

52. Have you gotten into physical fights as a result of your drinking or drug use? YES or NO

Other Concerns

53. Do you currently have concerns in any of the following: (Circle all that apply.)

Physical	Psychological	Spirituality
Medical	Family	Education
Nutrition	Relationships	Legal
Physical Fitness	Social Support	Sexual
Leisure	Recreational	Vocational
Military Service	Financial	Other

Please explain: _____

_____

54. Are you having thoughts of harming others or yourself? YES or NO

55. In the past I had mental health treatment/counseling for: _____

56. On a scale of 1 – 10, 1 being LOW, 10 being HIGH, how would you rate your level of motivation for treatment if it were recommended? _____

Signature: _____ Date: _____

Counselor: _____ Date: _____

Patient Name	Rank/Grade	Sex